



ANIMAL BITE/EXPOSURE REPORT

SALEM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

110 Fifth Street, Suite 400 – Salem, New Jersey 08079

856-935-7510, ext. 8448 Emergency/After Hours call: 856-769-1955

FAX REPORT TO: 856-339-4190

(Physicians must report bites to the local health dept. within 12 hours of attendance per NJAC 26:4-79)

SCDHHS ID#:

VICTIM	Name of Victim:		Age:	Cell Phone:	
	Name of Parent/Guardian if Victim is a Minor:		Daytime Phone Numbers:		
	Address:		City:	State:	Zip:
	Municipality:	County:	Address and County where incident occurred:		
	Has the victim ever been vaccinated for rabies before?: <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, Date:				
List any other pets or persons bitten or exposed:					
INCIDENT	Date and Time of Incident:		Part of Body Bitten or Exposed:		<input type="checkbox"/> Bite <input type="checkbox"/> Skin Broken <input type="checkbox"/> Scratch <input type="checkbox"/> Bat <input type="checkbox"/> Saliva/Fluids <input type="checkbox"/> Other
	Description of how the bite or exposure occurred:				
	Did the Animal have any of the following symptoms: <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Overly Friendly or Fearless <input type="checkbox"/> Choking or Difficulty Swallowing <input type="checkbox"/> Sagging Jaw <input type="checkbox"/> Seizures <input type="checkbox"/> Staggering/wobbling <input type="checkbox"/> Paralysis <input type="checkbox"/> Making unusual crying sounds Other:				
	Name of any Animal Control Officers Involved:				Phone:
TREATMENT	Name of any Veterinarians or Others Involved:				Phone:
	Name of any Doctor or Hospital visited or consulted:				Phone:
	Describe Treatment given or recommended: <input type="checkbox"/> Tetanus <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other				
	Was Rabies Post-Exposure Treatment/Prophylaxis started?: <input type="checkbox"/> NO <input type="checkbox"/> YES * (see next line) If YES, Date:				
*If Yes, the treating Doctor or Hospital/Clinic must send a REPORT OF RABIES POST-EXPOSURE TREATMENT (form CDC-2) to the local Health Department (see fax number above). The form is available at http://www.state.nj.us/health/forms/cdc-2.pdf					
ANIMAL/OWNER INFORMATION	Type of Animal:		Animal is:		
	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat Other:		<input type="checkbox"/> Victim's Pet <input type="checkbox"/> Owned by another <input type="checkbox"/> Unknown <input type="checkbox"/> Wild <input type="checkbox"/> stray/Feral <input type="checkbox"/> Livestock Other:		
	Animal Description (Breed, Color, Markings, Sex):				
	Name of Owner:		Cell Phone:	Daytime Numbers:	
	Address:		City:	State:	Zip:
	Municipality:	County:	Animal's Location: <input type="checkbox"/> Owner's Property <input type="checkbox"/> Loose/Unknown <input type="checkbox"/> Vet <input type="checkbox"/> Shelter <input type="checkbox"/> Other :		
	Address where animal is currently located if different from Owner:				Phone:
	If Euthanized, reason for doing so: <input type="checkbox"/> Sick <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Other:		Date:	Location of the body:	
	Is/was the animal current on it's rabies vaccinations? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		Date of last shot:	Expiration:	
	Name of Veterinarian:				Phone:
SCDHHS	Was animal current on rabies vaccination? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		Was animal tested for rabies? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		Results if tested for rabies: <input type="checkbox"/> Positive/Unsatisfact. <input type="checkbox"/> Negative
	Was confinement ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO		Type of Confinement/Release Ordered: <input type="checkbox"/> 10 day observation <input type="checkbox"/> 45 day observation <input type="checkbox"/> 4 month standard <input type="checkbox"/> 4 month strict		Was PEP recommended for victim? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Confinement Dates: Start: End:		Confinement Release Performed: Date: Inspector Initials:		